Spencer Hospital
Clay County Public Health
Healthier Together.

COVID-19 Pfizer Vaccine Consent

Dose #1

Name: _____ Date of Birth: _____ Age:_____

Maiden Name: _____ Gender: ☐Female ☐ Male

Address: _____City: _____State: _____ Zip: _____

Phone Number: _____ Medical Provider: _____

Emergency Contact or Parent: _____ Phone: _____

Please answer the questions below. If you answer 'yes' to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

Are you feeling sick today?	☐ Yes	☐ No	☐ Don't Know
Have you received a COVID-19 vaccine previously? If yes: Date 1st Dose: _____Date 2nd Dose: _____ If yes: Which vaccine? ☐ Pfizer ☐ Moderna ☐ Other:	☐ Yes	☐ No	☐ Don't Know
Have you ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving a COVID-19 vaccine?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving another vaccine or injectable medication?	☐ Yes	☐ No	☐ Don't Know
Have you received antibody therapy (such as monoclonal antibodies or convalescent plasma) as treatment for COVID-19? If yes, date of treatment: _____	☐ Yes	☐ No	☐ Don't Know
Have you received another vaccine in the last 14 days?	☐ Yes	☐ No	☐ Don't Know
Have you tested positive for COVID-19? If yes: Date	☐ Yes	☐ No	☐ Don't Know
Do you have a weakened immune system (such as HIV or cancer) or do you take immuno-suppressive drugs or therapies?	☐ Yes	☐ No	☐ Don't Know
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Don't Know
Are you pregnant or breastfeeding?	☐ Yes	☐ No	☐ Don't Know
Do you have dermal fillers?	☐ Yes	☐ No	☐ Don't Know

By signing the consent, I acknowledge that I understand the following:

- The FDA has authorized the emergency use of the Pfizer COVID-19 Vaccine that may prevent COVID-19. This vaccine is not FDA-approved. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine for individuals age 16 and older.
- This vaccine is a 2-dose series and I must receive both doses in order to achieve the best immunity. I need to make sure that I receive that second dose as close to 21 days after my first dose as possible.

Vaccination Release

I have read or have had explained to me the information on the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and consent to the vaccine be given to me or to the person for whom I am authorized to make this request.

Printed name: _____ Signature: _____ Date: _____

OR

Parent Name: _____ Signature: _____ Date: _____

(*if patient under age 18*)

**********For Office Use Only**********

Date: Dose #1	Manufacturer	Lot #	Exp Date	VIS/EUA Date	Dose	Site	Adm By	IRIS date/initial
	Pfizer			2/25/2021	0.3 ml	R L Deltoid		